



Virginia Commonwealth University
VCU Scholars Compass

Case Studies from Age in Action

Virginia Center on Aging

2010

CPR and DNR Decision Making

Viki Kind

Follow this and additional works at: http://scholarscompass.vcu.edu/vcoa__case



Part of the [Geriatrics Commons](#)

Copyright managed by Virginia Center on Aging.

Recommended Citation

Kind, V. (2010). CPR and DNR Decision Making. *Age in Action*, 25(3), 1-5.

This Article is brought to you for free and open access by the Virginia Center on Aging at VCU Scholars Compass. It has been accepted for inclusion in Case Studies from Age in Action by an authorized administrator of VCU Scholars Compass. For more information, please contact libcompass@vcu.edu.

Case Study

CPR and DNR Decision Making

by Viki Kind, M.A.

Educational Objectives

1. Examine the complexities of end-of-life care and obstacles to good DNR decision making.
2. Discuss CPR and its perceived vs. actual chances for success.
3. Demonstrate best practices for communicating about CPR.
4. Consider how the signing of the DNR is just one component of end-of-life care.

Background

Older adults and their loved ones are being asked to make difficult end-of-life choices about CPR (cardiopulmonary resuscitation) and its refusal, DNR (do not resuscitate). These decisions are fraught with angst and misinformation. CPR or cardiopulmonary resuscitation used to be simple to understand. "Cardio" refers to the heart, pulmonary the lungs, and resuscitation means to revive from death. In the past, we used CPR only with patients who

were having a heart attack and who might benefit from receiving CPR. When a patient died, someone would push on the person's chest to try to restart the heart, while giving mouth-to-mouth resuscitation to help the person breathe. Over time, CPR has become more complex, as healthcare professionals have discovered different and advanced ways to try to bring the person back to life. The patient may be given medications, his heart may be electrically shocked with paddles placed on the chest, and he may be placed on a ventilator to help him breathe. Every year, researchers find new ways to adapt the CPR process to try to save more lives. What seemed like an easy question, "Does the person want CPR?" has turned into a more complicated decision. Now we use it for everyone, including those in a terminal state, whether it will work or not.

Because the general public does not understand the advances in CPR, the first step of the DNR conversation should not be, "Do you want CPR?" but "What do you know about CPR?"

CPR and DNR in Practice

Today, many do not realize that, when the doctor says CPR, she is including medications, intubation, and ventilator support. A common misunderstanding occurs when people are given the misleading choice of a "chemical code only." As nurses and doctors will attest, if the doctor gives the medicine but does not make the chest compressions to move the blood around, the medicine will not circulate in the body. Without circulation, the medicine cannot do its job.

Another factor is that the decision about CPR has become, inappropriately, an indicator of a person's complete end-of-life wishes; but the decision about CPR should be only one part of the treatment plan. A patient may want chemotherapy, surgery, radiation therapy or other kinds of aggressive treatments and still may not want CPR. Or the person may not want other medical treatments but still wish to receive CPR. These are all separate decisions and any combination is possible.

Inside This Issue:

VCoA Editorial, 5
VDA Editorial, 6
Staunton Music, 7
Road Scholars, 8

Back to School for LLI, 9
ARDRAF 2010-11 Winners, 10
VCoA Focus: Kimberly Ivey, 13
Living Too Long Revisited, 14

Food Labeling Confusion, 16
Bob Blancato Honored, 17
State Bar Resource, 17
Calendar of Events, 18

The doctor may at some point ask the family decision maker, “Should the patient be made a DNR?” DNR means *Do Not Resuscitate* or do not do CPR. The answer given may depend on how the question is asked. One positive change is that the language of DNR has been modified to “Do Not Attempt Resuscitation” (DNAR) or “Allow Natural Death” (AND). Both of these semantic changes help to clarify the confusion. Do not attempt resuscitation truthfully explains that just because CPR is attempted, there is no guarantee that it will work. If one were to ask healthcare professionals, “How many of you would like to die by CPR?” no one would ever raise a hand. What they know, but do not always share with their patients, is that the chance of CPR working is minimal, sometimes nil. On television shows like *ER*, CPR brings the patient back to life about 75 percent of the time (Diem, Lantos & Tulsky 1996), while in real life it only works, at best, about 17 percent of the time on healthy patients (Peberdy, et al. 2003). In many real-life situations, the chance of success is zero. Gordon (2009) and Ehlenbach (2009) both note that CPR is most likely to succeed when the heart is the problem, such as in an ongoing heart attack or a heart rhythm disturbance, but that its prospects for success with someone in intensive care with a serious infection and multiple organ failure are unlikely.

The newest term, Allow Natural Death or AND, is a more gentle way of saying do not resuscitate. Instead of stating what would not be done for the patient, the physician is offering to allow the patient a peaceful, natural death and will

not attempt resuscitation. The CPR/DNR decision is about more than medicine. It frames the dying experience for the patient and the loved ones. For those who are making the CPR/DNR decision, it is important to balance the chances of CPR working and bringing the person back in a good condition with the desire for a good, peaceful, and dignified death. This is why healthcare professionals wouldn’t want to die by CPR; there is nothing peaceful or dignified about this type of death.

Improving Communication

How can the healthcare team help guide a significant other or adult children through this decision making process? What are the underlying issues that will make the decision more difficult to make? What statistical information might make the decision easier? What grief support can the healthcare team provide to ease the process? The following case studies illustrate the complexities of decision making.

Case study #1

Mr. Jackson is a 67-year-old man who has end-stage Alzheimer’s, is unable to eat, and recently had a feeding tube placed. He does not have an advance directive and never told his children what he would want done in circumstances he now faces. Unfortunately, his physician did not ask about his CPR wishes when Mr. Jackson was in the early stages of the disease. The physician is now asking, “Would he want CPR?” His adult children have been through much over the past years and are overwhelmed by the question. The

thoughts running their minds are, “Is it time?” “Are we giving up?” “I don’t want to make this choice but I can’t stand watching him suffer any longer.” “If I make this decision, does that mean I have lost my faith?”

How can we as aging professionals help those we serve, as they struggle with these difficult decisions? One of my roles as a bioethicist is to assist families, like Mr. Jackson’s, who are making the difficult decisions. I am not there to tell the family or healthcare team what to do, but to help those involved to think through the issues, so they can make a more informed decision. It is important during these conversations that we keep the patient’s wishes and needs at the forefront.

When working with Mr. Jackson’s son and daughter, I would make sure they are educated about CPR. Hopefully, Mr. Jackson’s doctors will not have eroded the trust and created a confrontational relationship by pushing for the DNR. I would need to be patient, as these end-of-life conversations are a process, not a one-time event.

I would make sure Mr. Jackson’s children understand the possible outcomes of CPR. He may survive CPR but never be able to leave the hospital or he may be hooked up to ventilators for the rest of his life. Research has found that, if CPR is able to bring a patient back to life, the chances of the survivor going home with good brain function is only about seven percent (Kaldjian, et al., 2009). In Mr. Jackson’s compromised condition, his prospects are even poorer. Typically, the suc-

cess rate of CPR will depend on the health of the patient, the patient's age, how quickly the CPR was begun, and other medical factors.

Next, I would make sure the family understood what can happen during CPR. Mr. Jackson may be brought back to life but in a worse condition than before, both mentally and physically. There is a chance of broken ribs, a collapsed lung, damage to the windpipe, and the longer he is unable to breathe, the greater the chance for brain damage.

Once the family understands the limits on CPR's working and what kind of outcomes might be expected, I would then point out that by their choosing CPR, Mr. Jackson may not have the opportunity for a peaceful and meaningful death experience. I would ask his children, "When your father pictured the last minutes of his life, did he see strangers straddling him on a bed, pushing on his chest, with his family waiting outside his door? Or would your father want his family and friends gathered around his bedside, with words of love being expressed, music being played or prayers being said?" By asking these important questions, I hope to contextualize the medical choices by explaining what it will be like for their father to experience CPR versus a more peaceful death.

Often it is necessary to address and to help relieve the guilt and angst of making these difficult decisions. One gift I may be able to give Mr. Jackson's children is to help them to understand that it is not really their decision. It is the patient's decision. I would explain that, as the decision makers, they are sup-

posed to consider all that they know about their dad, what he has told them in the past, his values, and what would be important to him. Using this information, they should do their best to make the decision they think their father would make, that is, substituted decision making.

I would gently ask, "What would your dad be telling us if he were able to speak right now? What would your dad say about wanting CPR?" Then I would be quiet and let them sit with the question. In most situations, the family will know the answer, but it will be painful for them to verbalize the choice. I would then acknowledge how loving and courageous they are to honor their father's wishes. No matter what decisions are made, it will be important that this family receive emotional and spiritual support as they struggle with these issues.

Case Study #2

Mrs. Garcia is an 83-year-old woman who has multiple sclerosis. Her Advance Directive states that she does not want CPR. Her multiple sclerosis has developed to the stage where she has lost capacity. Her husband is both her decision maker and caregiver and he knows her wishes. Last week, Mrs. Garcia suffered a heart attack and is in the ICU. This morning she coded and was brought back to life by CPR. Her husband has just been called to come to the hospital and was told that his wife survived CPR but her condition is deteriorating. What went wrong? Why wasn't her DNR honored? What is Mrs. Garcia's expected outcome after receiving CPR?

What went wrong? Unfortunately, this scenario happens more often than it should. When Mr. Garcia received the call about his wife, he was shocked and angered. How could this have happened?

There are a few possibilities. Some physicians will not agree to a DNR because of moral opposition and, therefore, will not write or respect a DNR. While physicians are certainly allowed to live by their morals and to refuse to participate in acts that go against their values, they are still obligated to inform patients about valid medical options and then to let the patient or decision maker decide. If the physician is unwilling to do this, then he or she should help the patient to find another doctor who is willing to talk about the DNR option. If the patient, family or someone from the healthcare team is worried about the patient's rights being violated, he or she should call for a bioethics consult from the hospital's bioethics committee.

Another possibility in Mrs. Garcia's case is that the DNR request from her Advance Directive was not transferred onto her hospital chart. If the DNR is not on the chart, it does not exist in practicality. Whether one is the patient, the loved one or someone working with the family, it is necessary to review the patient's Advance Directive and other healthcare wishes with the physician and to make sure that they are documented.

A final possibility is that medical miscommunication occurred. Perhaps the Advance Directive was not sent up from the emergency room, the team couldn't find the DNR, no

one took the time to look for it, the covering physician was unfamiliar with the patient or numerous other mishaps. As much as we would all wish for the practice of medicine to be perfect, healthcare is significantly flawed and human.

What should happen next in Mrs. Garcia's case? The first step will be to make sure the DNR order is written immediately. I would hope that apologies would come next. Administration, risk management, and other hospital staff will be involved in resolving this situation. This event will be evaluated to determine what caused this medical error and to take steps to make sure it does not happen again. (It will happen again, but usually not to the same patient.)

Ultimately, the physician will need to sit down with the family and talk about where to go from here. Since the CPR was performed, what is her condition? What options are available that would be respectful of Mrs. Garcia's wishes? Is it time for a hospice referral? Perhaps the physician who performed the CPR may not be the best person to handle the situation at this point because of broken trust. It may be necessary to bring in a different consultant to help bring peace to this situation. It will also be important to address Mr. Garcia's anger and frustration with the hospital and the healthcare team. He will probably be devastated that his wife's wishes were not honored and that she is still suffering. Appropriate social services should be brought in to help him with his grief.

Upon fuller evaluation of the event, it did appear that it was not that

Mrs. Garcia's wishes were disrespected, but that her wishes were not known (because no one had read her Advance Directive) and the CPR/DNR conversation never occurred. This, too, is also a common problem in healthcare. As mentioned, quite a few physicians are uncomfortable talking about end-of-life issues. Again, it is my hope that healthcare professionals do not simply talk about the medical choice of CPR but rather discuss what kind of life one would want after CPR and what kind of death one would desire. The following questions are just as important as, "Do you want CPR?"

- Where would the person want to die?
- With whom would the person want to be as he or she dies?
- What would bring peace and comfort during the dying process?
- For many people, CPR prolongs the dying process. Is this okay?

Conclusion

The conversation about CPR and other end-of-life decisions is a journey of informing, understanding, and helping to support the person who has the difficult choices to make. As professionals, we have to find the courage to walk with our critical patients as they move through their illness and toward death. As patients and family members, we have to recognize that it is important to have these conversations early, to ask for the answers and support we need. If the physician is unwilling to help in these tasks, find another who will. If, after talking with the physician, we realize that he or she will not respect or support the patient's

wishes, we should find one who will. Once the process has produced a decision, write it down and tell others. Don't make them guess.

A final thought: the intention of this review has not been to dismiss or preclude someone's choice to attempt CPR. Rather, it has been to help ensure that patients and their loved ones have a fuller understanding of the facts surrounding CPR, the chances of its working, the likely condition of the person after CPR, and the manner of death that is being chosen. May we all make wise and informed decisions for ourselves and for those in our care.

Study Questions

1. What are common misunderstandings about CPR?
2. When discussing DNR, what other issues should be raised?
3. What issues impede good decision-making for one's loved one?
4. What decision would you make personally regarding CPR/DNR and how might this affect how you interact with those you serve?

References

- Diem, S. J., J. D. Lantos, and J. A. Tulsky. (1996). Cardiopulmonary resuscitation on television: Miracles and misinformation. *New England Journal of Medicine*, 334(24), 1578–82.
- Ehlenbach, W.J., A.E. Barnato, J.R. Curtis, et al. (2009). Epidemiologic study of hospital cardiopulmonary resuscitation in the elderly. *New England Journal of Medicine*, 361(1), 22–31.

Gordon, S. (2009). CPR survival rates for older people unchanged. *HealthDay: News for Healthier Living*, July 1, 2009. Retrieved from <http://health.usnews.com/health-news/family-health/boomer-health/articles/2009/07/01/cpr-survival-rates-for-older-people-unchanged.html>.

Kaldjian, L.C., Z.D. Erekson, T.H. Haberle, et al. (2009). Code status discussion and goals of care among hospitalized adults. *Journal of Medical Ethics*, 35(6), 338–42.

Peberdy, M.A., W. Kaye, J.P. Ornato, et al. (2003). Cardiopulmonary resuscitation of adults in the hospital: A report of 14,720 cardiac arrests from the National Registry of Cardiopulmonary Resuscitation. *Resuscitation*, 58. 297-308

About the Author



Viki Kind is a clinical bioethicist, medical educator, and hospice volunteer who practices in Los Angeles.

She earned a master degree in bioethics from the Medical College of Wisconsin. Viki is a member of the Los Angeles County Bar Association's Bioethics Committee and the Southern California Bioethics Committee Consortium. Her book, *The Caregiver's Path to Compassionate Decision Making: Making Choices for Those Who Can't*, guides families and healthcare professionals through the difficult process of making decisions for those who have lost capacity. She lectures nationally to healthcare professionals on improving integrity, compassion and end-of-life care through better communication.